



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 12, 2023

Licensee
Care4u Home Care Services, LLC
13704 Portland Avenue South
Burnsville, MN 55337

RE: Project Number(s) SL38633015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on April 26, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

In accordance with Minn. Stat. § 144G.31, Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; however, no immediate fines are assessed for this survey of your facility.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter

as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Paul G. Spencer". The signature is written in a cursive style with a long, sweeping underline.

Paul Spencer, Supervisor
State Rapid Response Team
Email: paul.spencer@state.mn.us
Telephone: 651-587-4460 Fax: 651-215-6894

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER CARE4U HOME CARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13704 PORTLAND AVENUE SOUTH BURNSVILLE, MN 55337		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL38633015-0 On April 17, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were three residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time;	0 460		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 460	Continued From page 1 (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs as required. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. During the tour of the home on April 18, 2023, at	0 460		

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0 460	Continued From page 2 10:35 a.m., a first-floor resident room was observed. No evidence of a call system was seen in the room. During the tour, registered nurse (RN)-B stated the facility did not have a formal call system in place for residents to request assistance when needed. RN-A stated that if residents need anything they verbally "call out" to the staff person who is right in the living room, kitchen area. Policy titled Minimum Assisted Living Facility requirements 144G.41 indicated the licensee shall maintain the minimum requirements of this policy. Subpart e. Provide means to request assistance 24 hours per day seven days a week. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 480		

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0 480	Continued From page 3 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Report dated April 18, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 660		

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0 660	Continued From page 4 licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation and screen for active and latent TB for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: SCREEN FOR ACTIVE/LATENT TB ULP-C's employee record lacked documentation of a complete two step screening for active/latent TB. ULP-C's record included documentation of a negative TST on August 8, 2022; however, a second TST was not completed. ULP-C was hired on May 25, 2022, to provide direct care to residents under the assisted living license. On April 19 at 9:08 a.m. RN-A confirmed that ULP-C had not completed the second TST step. The licensee's TB Prevention & Screening Plan, undated, indicated the licensee will follow the recommended precautions related to TB prevention as identified by the CDC and with the MN Department of Health (MDH). The plan will include a TB committee to monitor, assess risk and changes as needed. Screening included baseline testing at time of hire for all home care	0 660		

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0 660	Continued From page 5 workers in MN which consists of two components: assessing for current symptoms of active TB disease 2- testing for the presence of infection of mycobacterium tuberculosis by administering a two-step TST or a single blood test. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure it completed a written emergency disaster plan with all required content outlined in Appendix Z. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 19, 2023, at approximately 12:55 p.m. a request was made to view the licensee's emergency preparedness plan. The plan contained in a three-ring binder labeled Emergency Preparedness Housing with Services, contained various emergency situations, including detailed instructions on how staff should respond in the event of a chemical or biological incident or attack. It also contained minimal direction on making an emergency plan, and listed various emergency situations (such as heat, several weather emergencies, emergency evacuations, plan activations); however, the procedures spelled out in the plan were generic, lacking specificity to the facility. The facility's plan lacked the following required content: -all hazards-based emergency preparedness	0 680		

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0 680	Continued From page 7 program with a risk assessment considering all hazards that may impact all or a portion of the facility; assessment and assignment pages were blank. -an assessment of the at-risk population's needs. -a missing resident plan. -a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations. -subsistence needs for staff and residents during emergency situations. -procedure for tracking staff and residents. -development of all policies and procedures, based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents and how the facility will provide care under an 1135 waiver declared by the Secretary. -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services. -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. On April 19, 2023, at 12:30 p.m., RN-A confirmed that all emergency preparedness documents had	0 680			

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0 680	Continued From page 8 been provided. The licensee's "Emergency Preparedness" policy, undated, indicated the licensee will have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide smoke alarms outside and in the immediate vicinity of the sleeping rooms throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 19, 2023, at approximately 10:00 a.m. with registered nurse (RN)-A it was observed that smoke alarms were not provided outside and in the immediate vicinity of the main floor sleeping rooms. All smoke alarms are required to be interconnected. On the same facility tour it was observed smoke alarms were not provided in the sleeping rooms in the basement. All smoke alarms are required to be interconnected. This deficient finding was visually verified by RN-A at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 790	Continued From page 10	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required service of the portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 19, 2023, at approximately 10:00 a.m. with registered nurse (RN)-A it was observed that each of the fire	0 790		

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0 790	Continued From page 11 extinguishers provided were not serviced as required and the gauge indicated the extinguishers were empty. RN-A visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 800			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CARE4U HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13704 PORTLAND AVENUE SOUTH BURNSVILLE, MN 55337		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 12 Findings include: On a facility tour on April 19, 2023, at approximately 10:00 a.m. with registered nurse (RN)-A it was observed that an exit sign was located at the door leading to the attached garage. Exits are required to be maintained and lead directly to the exterior and not through a higher hazard room. It was observed the gas water heater vent was in close contact with combustible material in the basement mechanical room. Required clearance to combustible shall be maintained for gas appliance vents. Please consult a mechanical contractor for gas vent clearance requirements. It was observed carbon monoxide alarms are installed but not outside and within 10' of all sleeping rooms according to MN Statute. These deficient conditions were visually verified by RN-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810			

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0 810	Continued From page 13 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 14 or has potential to affect a large portion or all of the residents). A record review of available documentation and interview were conducted on April 19, 2023, at approximately 9:15 a.m. of documents provided by registered nurse (RN)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated the fire safety and evacuation floor plan did not include numbers for resident rooms. Record review of the available documentation indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have detailed fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees in regard to resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan.	0 810		

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0 810	Continued From page 15 Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. All deficiencies were verified by RN-A during the interview at approximately 9:30 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the	01440			

Minnesota Department of Health

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01440	Continued From page 16 individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN)-A conducted supervision of unlicensed staff as required for one of one unlicensed personnel (ULP)-C with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: The licensee held an assisted living license. On April 19, 2023, at 11:45 a.m., ULP-C's employee file was reviewed. ULP-C 's start date was recorded as May 25, 2022. ULP-C's employee record lacked evidence RN-A conducted direct supervision of the employee performing a delegated task within 30 days the employee had first performed the delegated task for residents. On April 26, 2023, at approximately 10:15 a.m., RN-A and administrator (ADM)-B acknowledged supervisory assessments had not been completed with ULP-C within 30 days after the	01440		

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01440	Continued From page 17 date ULP-C performed delegated tasks for the residents. Licensee policy titled Delegation and Supervision of Staff, undated, indicated all unlicensed staff will be supervised by a staff RN within 30 days of hire to ensure they are performing job duties competently. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01440			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two	01530			

Minnesota Department of Health

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01530	Continued From page 18 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure one of one employees (unlicensed personnel (ULP)-C) received the required amount of dementia care training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Review of employee record for ULP-C indicated ULP-C had a hire date of May 25, 2022, and provided direct care and services to the licensee's residents. ULP-C's record lacked evidence of at least eight hours of initial dementia care training within 160 working hours of employment start date, and the required topics. On April 26, 2023, at 10:15 a.m. registered nurse (RN)-A verified ULP-C 's record lacked documented evidence of at least eight hours of initial dementia care training. The licensee's Dementia Care Training policy, undated, indicated direct care employees would complete eight hours of initial training within 160 hours of the employment start date and the	01530		

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01530	Continued From page 19 training would include the required topics - An explanation of Alzheimer ' s disease and other dementias - Assistance with activities of daily living - Problem solving with challenging behaviors - Communication skills - Person-centered planning and service delivery. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01530		
01650 SS=C	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650		

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01650	Continued From page 20 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan dated June 1, 2022 indicated R1 received comprehensive home care provider services. The plan refers to Home care services and comprehensive home care provider throughout the plan. On April 26, 2023, at approximately 10:00 a.m. registered nurse (RN)-A confirmed the service plan lacked the required assisted living license requirements. The licensee's Service/Agreement Plan indicated the services provided fell under a Comprehensive home care provider or Basic home care provider. The assisted living licensure 144G was not listed	01650		

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01650	Continued From page 21 as a plan on the service agreement. The multi-paged service plan referred to responsibilities of a home care provider and not an assisted living provider. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			

Type: Full
Date: 04/18/23
Time: 11:00:00
Report: 8041231096

Food and Beverage Establishment Inspection Report

Page 1

Location:

Care 4U Home Care Services LLC
13704 Portland Ave South
Burnsville, MN55337
Dakota County, 19

Establishment Info:

ID #: 0041187
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. EXCLUSION AND LOGGING REQUIREMENTS REVIEWED.
MDH LOG FORM SENT TO OPERATOR.

Comply By: 04/18/23

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

FACILITY IS SAVING LEFTOVERS SUCH AS CHICKEN AND EGGS. DISCONTINUE COOLING AND RE-SERVICE OF COOKED FOODS.

Comply By: 04/18/23

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 37 Degrees Fahrenheit - Location: kitchen cooler: egg

Violation Issued: No

Process/Item: Cold Holding

Temperature: 38 Degrees Fahrenheit - Location: kitchen cooler: chicken

Violation Issued: No

Type: Full
Date: 04/18/23
Time: 11:00:00
Report: 8041231096
Care 4U Home Care Services LLC

Food and Beverage Establishment Inspection Report

Page 2

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	0	1

Inspection was completed with Yun Yann (Nurse/Owner). Christine Bluhm was the lead Health Regulation Division Nurse Evaluator. Facility had five residents on site at time of inspection. No food preparation was observed during inspection. Residents typically eat lunch off site at adult daycare.

This establishment has a residential kitchen. Food must be prepared for same day service only. Kitchen has a tile floor and wood cabinets with a hollow base and laminate countertops.

A two basin sink is located in the kitchen with one basin designated for handwashing. Per operator, the Kenmore (NSF-residential) dish machine was recently tested and has a utensil surface temperature of at least 160 Deg. F.

Discussed the following:

- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Proper cold holding and food storage
- Date marking
- Vomit clean-up procedures
- Restrictions concerning serving a highly susceptible population

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041231096 of 04/18/23.

Certified Food Protection Manager: Sothy Ngun Vong

Certification Number: fm111399 Expires: 06/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Yune Yann
Nurse & Owner

Signed: 

Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us